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Issue date: 30Nov2001

In the matter of
Bobby Wayne Addison
Claimant
v.
Shady Lane Coal Co.
Employer

and
Director, Office of Workers* Compensation Programs
Party in Interest

Case No. 2001 BLA 0574

DECISION AND ORDER

Approving Claim

This case comes on a request for hearing pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 et seq. (the Act).[1] A hearing was held on July 23, 2001 in Abington, Virginia. The Claimant was represented by Joseph Wolfe, Esquire, Wolfe and Farmer, Grundy, Virginia. The Employer was represented by William E. Brown, Esquire, Thornsbeny, Brown, Lycan and Newman, Lexington, Kentucky. Thirty three (33) Director*s Exhibits were entered into evidence.[2] The Claimant offered three exhibits, which were admitted into evidence. Three Employer*s exhibits were also entered. Testimony was received from the Claimant. Post hearing, Employer filed a brief, which is admitted into the evidence, along with the transcript of hearing.

This claim was filed July 6, 2000 (DX 1). The Claimant alleges that he stopped working June 14, 2000 as a result of a lack of "breath" and a feeling that he is smothering (Id). He listed his date of birth as February 22, 1948. He listed his wife, Sherri, as his dependent (Id.). Their marital status is confirmed by a copy of the Virginia marriage certificate (DX 8). An initial notice of finding favorable to the Claimant was entered November 25, 2000 (DX 25). The Claimant has been in pay status as of July 1, 2000. A request for hearing was requested January 31, 2001 (DX 29).

Issues

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[1] And the regulations at 20 C.F.R. Ch. VI, Subch. B (the Regulations).

[2] References to "DX"exhibits of the Director. Claimant*s exhibits are marked "CX". Employer*s exhibits are marked as "EX". The transcript of the hearing is cited as "Tr." and by page number.

A miner must prove whether: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner*s total disability is caused by pneumoconiosis. ***Gee v. W G. Moore and Sons***, 9 B.L.R. 1-4 (1 986)(en banc); ***Baumgartner v. Director***, OWCP, 9 B.L.R. 1-65 (1986)(en banc).

At hearing, the parties stipulated to the following:

1. The claim was filed in a timely manner.
2. The Claimant worked for twenty years in coal mine employment (Tr., 26-27).
3. Shady Lane Coal Corporation is the responsible operator in this case (TR., 27).

After a review of the complete record, the evidence substantiates the stipulation. During the course of the proceedings, the Employer advised that it contests the following:

- Pneumoconiosis — Simple and Complicated
- Causal Relationship
- Total Disability
- Cause of Disability
- Dependency
- Refiled Claims
- Modification, and,
- Other Issues.

Burden of Proof

"Burden of proof" as used in the this setting and under the Administrative Procedure Act[3] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof.[4] "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)4. The drafters of the APA used the term "burden of proof* to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries [Ondecko]***, 512 U.S. 267, 114 S.Ct. 2251 (1994).[5]

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[3] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with "the APA"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers* Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[4] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP [Sainz]***, 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[5] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev. 1981).

A claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[6] Therefore, the claimant cannot rely on the Director to gather evidence. A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985).

Coal Miner

A "miner" is defined at 20 C.F.R. §§ 725.202(a) as the following:

> [A]ny person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. A coal mine construction or transportation worker shall be considered a miner to the extent such individual is or was exposed to coal mine dust as a result of employment in or around a coal mine or coal preparation facility.

20 C.F.R. §§ 725.101(a)(26) and 725.202(a). The Claimant advises that he worked and underground job as a roof bolter in the Employer*s mine (Tr. 10-13). I accept that the test is whether:

> (1) the coal was still in the course of being processed and was not yet a finished product in the stream of commerce (status);
>
> (2) the worker performed a function integral to the coal production process, i.e., extraction or preparation, and not one merely ancillary to the delivery and commercial use of processed coal (function); and
>
> (3) the work that was performed, occurred in or around a coal mine or coal preparation facility (situs).

Whisman v. Director, OWCP, 8 B.L.R. 1-96 (1985). The Fourth Circuit Court of Appeals has similarly held that the definition of a miner only includes the situs and function prongs. ***Collins v.Director, OWCP,*** 795 F.2d 368 (4th Cir. 1986); ***Eplion v. Director, OWCP***, 794 F.2d 935 (4th Cir. 1986).

The Claimant has established all three prongs of the test set forth above. As the parties have stipulated to twenty years of coal mine employment and the Claimant has established that he was a roof bolter (Tr., 10 -13), I accept that he is a "miner".

Post 1969 Employment

In the application, the Claimant advises that he worked for the Employer until June 14, 2000 (DX 1). On an Employment History form, the Claimant advises that he worked for the Employer from 1995 to June, 2000, and notes that at all times he was exposed to coal dust (DX 2). He testified to that also (Tr., 13).

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[6] *Id*., also see ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

Based on the above, I accept that the Claimant worked for the Employer until June 14, 1994, which is well after 1969.

Dependency

In the claim, the Claimant listed his wife, Sherri, as his dependent (DX 1). This is confirmed by a copy of the Virginia marriage certificate (DX 8). The Claimant substantiated the information and testified that she his his only dependent (Tr., 17-18).

20 CFR §725.205 sets forth the rules for a determination of dependency for a spouse:

> For the purposes of augmenting benefits, an individual who is the miner*s spouse (see 725.204) will be determined to be dependent upon the miner if:
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> (a) The individual is a member of the same household as the miner (see 725.232); or
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> (b) The individual is receiving regular contributions from the miner for support (see 725.233(c)); or
>
> (c) The miner has been ordered by a court to contribute to such individual*s support (see 725.233(e)); or
>
> (d) The individual is the natural parent of the son or daughter of the miner; or
>
> (e) The individual was married to the miner (see 725.204) for a period of not less than 1 year.

[43 FR 36772, Aug. 18, 1978, as amended at 48 FR 24290, May 31, 19831

The record shows that Mrs.Addison has been married to the Claimant for more than one year. Therefore, I accept that she is a dependent for augmentation.

Evidence

The Claimant was examined by D.L. Rasmussen for the Department of Labor on September 26, 2000 (DX 9 - DX 11). Mr. Addison was 52 years of age. He reportedly began to experience shortness of breath with exertion four to five years prior to examination. He reported that he has no significant dyspnea after climbing a flight of stairs. However, Mr. Addison alleged he has significant dyspnea with heavy work. He described a chronic productive cough. He reportedly wheezes early in the morning, late in the evening and with exertion; also when exposed to hair sprays, etc. The Claimant said that sometimes he needs to sleep sitting up. He alleged that he occasionally awakens with shortness of breath and cough. He has had some swelling of his ankles. He stated he coughed small amounts of blood on several occasions. Mr. Addison described lower anterior dull aching and sharp pains rather constant, worse in the mornings when he awakens. He reported having had known systemic hypertension for three to four years. He denied having other cardiovascular illness. The Claimant stated he had pneumonia in the 90*s and has had attacks of wheezing, but denied other known respiratory illness. Dr. Rasmussen noted that Mr. Addison*s s hearing is relatively poor. His left ear is worse than the right, and reportedly has some ringing in it. Complaints of heartburn and indigestion were noted, along with frontal headaches and dizziness, along with the cough. The Claimant*s hands and knees are stiff and painful. His knees allegedly tend to give way. The Claimant*s weight is stable, but his nerves

are not too good. He reportedly gets shaky, upset and “down in the dumps”. He reportedly sleeps poorly. Id.

Mr. Addison reported that he first began to smoke regularly at age twenty (20), in 1968; he smoked an average of 1 pack of cigarettes a day until he quit in May 2000. He has never used illicit drugs. At the date of examination, he did not take regular medications (Id.). Mr. Addison told Dr. Rasmussen that he had been employed in the coal mining industry for some 35 years, between 1966 and May 2000. He reported that he worked initially as a hand loader, cutting machine operator and for 20 years was a roof bolter. His last job was that of roof bolter in low coal. Most of the time he was required to bend bolts. He set timbers when pillaring. He shoveled. He rock dusted, carrying fifty pounds of rock dust bags occasionally 100 to 150 feet; “Thus, he did considerable heavy manual labor.” Id.

On examination, Mr. Addison measured 68 3/4 inches tall and weighed 197 pounds. His blood pressure was noted as 160/88. The heart rate was 60, and respirations, 18. No abnormalities of his eyes, ears, nose or pharynx were noted. Dr. Rasmussen could hear no bruits. Breath sounds are reported as “moderately to markedly” reduced. No rales, rhonchi or wheezes were noted. Some prolonged expiratory phase with forced respirations was noted. The abdomen is described as soft and non-tender. A chest X-ray interpreted by Manu N. Patel, M.D., “a Board Certified Radiologist and B-Reader”, indicated pneumoconiosis t/q with a profusion of 2/1, affecting all lung zones (DX 13).
The FEV1 was 2.07, the FVC 4.07, and the MVV was 61. According to Dr. Rasmussen, the ventilatory function studies revealed a “moderate, slightly reversible obstructive insufficiency”. Maximum breathing capacity wasr eported as markedly reduced; however, it was less than the calculated values of 83 and 91 L/min. respectively. The single breath carbon monoxide diffusing capacity was reported as normal. There was “minimal” resting hypoxia noted (DX 9-DX 11.).

An incremental treadmill exercise study was performed, beginning at 2.4 mph at an even (zero per cent) grade. This level was maintained for three minutes and thereafter the grade of the treadmill was increased at 2.5% per minute. Mr. Addison exercised for nine minutes and reached a maximum of 2.4 mph at a15% grade. He achieved an oxygen uptake of 23 .2 cc/kg/mm., which was 66% of his predicted maximum oxygen uptake. He did not report chest pain. His EKG and blood pressure responses were noted as normal. According to the report, he exceeded his anaerobic threshold normally at about 43% of predicted maximum oxygen uptake. His heart rate was reported to be within normal limits. His volume of ventilation was reportedly normal. He retained a breathing reserve of 34 liters. There was no increase in VD/VT ratio noted. There was, however, “significant” gas exchange impairment noted with hypercarbia and hypoxemia (Id).
According to Dr. Rasmussen, these studies indicate at least moderate loss of lung function. He opined that the Claimant does not retain the pulmonary capacity to perform his last regular coal mine job:

> The patient has a significant history of exposure to coal mine dust and x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that the patient has coalworkers* pneumoconiosis which arose from his coal mine employment... .There 2 risk factors for this patient*s impairment in lung function are his cigarette smoking and his coal mine dust exposure.

His coal mine dust exposure is a significant contributing factor.

Id.

Dr. Rasmussen*s examination was reviewed by John A. Michos, M.D., for the Department of Labor. He determined that both the pulmonary function studies and arterial blood gas studies are acceptable under the Act and Regulations. He did note that the MVV testing disclosed suboptimal performance (DX 12).

A reading of the September 26, X-ray was performed by Peter J. Barnett, M.D. (DX 14). He found no evidence of pneumoconiosis. Shiv Navani, M.D. read the same film as 1,0. DX 15. Kathleen A. De Ponte, M.D. made the same finding (CX 2). Jerome Wiot, M.D. read the same X-ray as grossly under exposed and totally unacceptable (EX 2).

On February 20, 2001, a CAT scan was performed at Johnston Memorial Hospital by Casey McReynolds, M.D. (CX 3). The Claimant had been complaining of shortness of breath. The report notes multiple benign appearing axillary lymph nodes, the majority of which are not pathologically enlarged. There are subcentimeter pretracheal, prevascular, and AP window lymph nodes. "Incidentally" noted are calcified splenic granulomata. The lung windows demonstrate a metallic artifact posterolaterally in the left apex. Calcified granuloma in the LLL.[7] There are no additional pulmonary masses or nodules. There is an additional calcified granuloma in the LUL.[8] There is a nodular interstitial pattern involving the mid and upper lung zones bilaterally which is consistent with coal worker*s pneumoconiosis given the patient*s history or perhaps silicosia. The diagnosis is:

1.Findings consistent with silicosis/pneumoconiosis.

2.Old granulomatous disease.

Id. A plethysmograph report showed that pulmonary function studies performed as part of the evaluation revealed an FEV1 of 1.86 or 56% of predicted. The FVC was 3.17 or 70% of predicted. There was an 18% improvement in the FEV 1 and 25% improvement in the FVC. The lung volume studies confirmed evidence of air trapping with a diffusion capacity of 88%. Id.

Dr. A. Dahhan performed an examination of the claimant for the Employer on February 23, 2001 (EX 1). He charted a history of smoking a pack per day beginning at the age of 18 with a stopping date in May, 2000 at the age of 52 with a total of 34 pack years. Dr. Dahhan noted a history of a daily cough with productive yellowish sputnum, but no hemoptysis. He has an intermittent wheeze on two (2) kinds of inhalers, but did not report the name of the inhalers. Id.

According to Dr. Dahhan, arterial blood gases at rest showed normal values and an exercise study was performed which also showed normal values for blood gases. The FEV1 is reported as 2.12; FVC is

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[7] Left lower lung.

[8] Left upper lung.

3/43 and MVV is 76. He stated that spirometric testing revealed an obstructive ventilatory defect with "significant response" to bronchodialator therapy. FVC studies were 76% of predicted values and FEV1 was 58% of predicted values. After bronchodialators, the FVC was 86% of predicted and FEVI was 65% of predicted. Lung volume measurements showed a residual volume of 129% of predicted and total lung capacity was 91% of predicted. Diffusion capacity was 121% of predicted values. A chest X-ray taken on February 23, 2001 was noted to have a film quality rating of 1 and showed a pellet in the upper chest with stable appearing granuloma in the left lower zone. No plueral or parenchymal abnormalities consistent with pneumoconiosis were seen. ILO classification was 0/0. Id.

As part of his examination, Dr. Dahhan reviewed other medical evidence including the report of Dr. Rasmussen and an X-ray report of Dr. Barnett. Dr. Dahhan found that there is insufficient objective data to justify the diagnosis of coal worker*s pneumoconiosis based upon the variable obstructive abnormality on clinical examination of the chest, obstructive defect on spirometry testing with significant response to bronchodialator therapy despite already being on two (2) inhalers, normal diffusion capacity and clear chest X-ray. Dr. Dahhan did find that the claimant has chronic obstructive lung disease as demonstrated by the physiological parameters of his respiratory system. But Dr. Dahhan opined that Claimant*s obstructive airway disease was not caused by, contributed to or aggravated by the inhalation of coal dust or coal workers* pneumoconiosis. Dr. Dahhan explained that the Claimant demonstrates significant response to bronchodialator therapy despite already being on treatment. Claimant*s family physician was providing him with bronchodialator therapy indicating that he believes that Mr. Addison*s condition is responsive to such therapy. Furthermore, Dr. Dahhan noted that the Claimant has no evidence of complicated coal workers* pneumoconiosis or progressive massive fibrosis. Finally, Dr. Dahhan noted that the Claimant has variable alterations in his blood gas exchange mechanisms which indicate that it is not a fixed defect. All of these findings are inconsistent with the permanent adverse effect of coal dust on the respiratory system. Id.

Dr. Dahhan also noted that Mr. Addison*s reported history of smoking for 34 pack years is more than enough to be injurious to the respiratory system and cause the development of a disabling obstructive respiratory abnormality such as the one that he now demonstrates. While Mr. Addison did not retain the physiological capacity to return to his previous coal mining work because of his obstructive airway disease, this impairment is not caused by coal workers* pneumoconiosis. Id.

Dr. Dahhan referenced the March 20, 2001 report of Dr. Wiot, which indicates that the chest X-ray taken on September 26, 2000 from Southwest Virginia Clinic is totally unacceptable for evaluation by ILO standards. He opined that the Department of Labor decision finding claimant was entitled to benefits was based upon reports misinterpreting "this grossly underexposed and totally unacceptable X-ray". Id.

Pulmonary function studies performed February 26 at Johnston Hospital revealed mild to moderate obstructive lung disease (CX 3).

On March 2, 2001 Dr. Emory Robinette saw Mr. Addison in his office for follow-up (CX 3). The Johnson Hospital CAT scan was noted to be consistent with the Claimant*s history of probable silicosis. A review of the pulmonary function studies performed as part of the evaluation at Johnston Hospital suggest to Dr. Robinette that this is evidence of interstitial pulmonary fibrosis due to his underlying black lung disease with cough and bronchial hyperactivity with some irreversible components. Serevent 2 puffs b.i.d. and Flovent 110 meg. 2 puffs bid were prescribed and Dr. Robinette gave him some samples of Singulair 10 mg. q.d. to ascertain if he would have any clinical response and asked him to use Combivent 2 puffs q. 4 hrs. p.r.n. for his cough and bronchial hyperreactivity.

On March 26, the Claimant underwent a bronchoscopy, performed by Dr. Robinette at Johnston Memorial Hospital (CX 3). On inspection there was similar bronchial wall pitting and erythema present compatible with an underlying diagnosis of chronic bronchitis. In view of the prior diagnosis of pneumoconiosis radiographically and his persistent cough, bronchial washings and brushings were obtained from the left upper lobe. On May 8, the Claimant returned to Dr. Robinette "for follow-up of his underlying black lung disease with associated areas or pulmonary fibrosis and silicosis, chronic bronchitis and a history of a recent bronchoscopy to evaluate his tracheobronchial tree." CX 3. According to the report, findings at bronchoscopy revealed evidence of bronchial wall pitting and chronic mucous production. No mass effect was seen. The right upper lobe was brushed. Bronchial washings and brushings were negative for acid fast bacilli. Cytologies were negative.

According to Dr. Robinette, the follow-up exam notes:

> Mr. Addison*s exhaled carbon monoxide level was 6 parts per million. Oxygen saturation at rest was 94%. HEENT was benign. His neck was supple without adenopathy. His chest on auscultation revealed diminished breath sounds with bilateral wheezes heard. There was prolongation of the expiratory phase. Heart was regular. No gallop or murmur raw present. Abdomen was generally soft, nontender. No masses.
>
> I had a long discussion with Mr. Addison concerning his chronic nicotine and cigarette smoke exposure. lie stated that his daughter was smoking heavily in the house. I strongly urged him to stop all secondary smoke exposure. I have placed him on Advair 100/50 1 puff b.i.d. I have urged him to stop all cigarette smoke exposure and will see him again in approximately 4 months with a follow-up chest X-ray.

Id.

An X-ray taken May 10 at Abingdon Radiology Services, Ltd. shows that there are multiple interstitial nodules in the mid and upper lung zones with pleural thickening laterally on the left. There are "shot gun" pellets noted projecting over the upper lung zones and right axillary regions. The lungs are otherwise noted as clear. The report opines:

Nodular interstitial lung disease with pleural thickening consistent with CWP[9]/silicosis. There is no acute process noted.

CX 3.

On July 29, 2001 the Claimant was examined by Randy Forehand, M.D (CX 1). Dr. Forehand noted that Mr. Addison is a 53-year-old-married, retired coal miner who was reportedly seen to determine the cause of progressively worsening shortness of breath of three years* duration. Mr. Addison reported that any time he has to walk more than 150 feet at a normal pace on flat ground such as walking to his mailbox and back, he has to stop and rest. He cannot climb more than one flight of steps without stopping to rest. He can no longer mow his lawn. He reportedly does bathe, dress and feed himself and moves from room to room in his house without difficulty. One year earlier, he was seen in a hospital emergency room for shortness of breath and was treated with oxygen, aerosol and was sent home with an albuterol inhaler. His shortness of breath reportedly requires him to use two pillows at night. Mr. Addison*s shortness of breath is accompanied by nighttime wheezing that is also noticeable when he exerts himself; a cough productive of two tablespoons full per day of a black, non-bloody phlegm and chest pain that is most noticeable during exertion or spells of coughing. Mr. Addison*s respiratory symptoms are reportedly present daily on a perennial basis without seasonal or environmental variability. Mr. Addison denies previous myocardial infarction, croup, hayfever, hoarseness, aspiration, a previous history of cancer, childhood asthma, thyroid disorders, congestive heart failure, heart murmurs, palpitations, syncope, cyanosis, pleurisy, phlebitis, aneurysm, fever, chills, night sweats, ankle swelling, hemoptysis, loss of appetite, weight loss or exposure or treatment of tuberculosis. Mr. Addison smoked one pack of cigarettes daily for thirty-four years from age 18 to 52 stopping one year prior to the examination. Mr. Addison reported that he was employed in underground coal mining as a roof bolt operator for 34 years from age 18 to age 52 at which time he retired. Mr. Addison said that he would be unable to return to his last job because of intolerable smothering, dusty conditions and the heat and humidity in the narrow seam of coal (36-40 inches) in which he worked. His job required that he crawl to and from the mine face and operate the equipment by bending over and crawling. He was required to lift and load bolts and operate the equipment in a bent-over or recumbent position while in front of the machinery then crawl to the back of the equipment in order to replace and move the bolter while lifting and carrying 30-pound power cables. He worked alone and because of the cramped nature of his work place was unable to wear a respirator. Mr. Addison reports that many times he had to leave the mine because of dizziness or from nearly passing out.

Also reported was a history of gastroesophageal reflux disease; chronic bronchitis, arthritis of the hands and legs; pelvis and rib fracture from roof fall (1970); and a crushed right thumb. In 1970, Mr. Addison also had a rib and pelvis fracture; in 1997, he was hospitalized due to shortness of breath and chest pain. Current medications include Advair, Singulair, Zoloft, Lotrel, Relafen and Prevacid.

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[9] Coal workers* pneumoconiosls.

Blood pressure is noted as 150/92 in the right arm and 150/88 in the left arm. The height is noted as 69 inches; weight as l90 pounds. Temperature is noted as 96.7 degrees, pulse 68, respirations 16. Mr. Addison was noted as a pleasant, cooperative man who appears to be in no acute distress at rest.

> Tidal respirations quiet. Not mouth breathing. No clubbing or cyanosis of the nailbeds. No rash. Eardrums are neither scarred nor retracted. Conjunctivae neither red nor swollen. The pupils are equal, round and react to light directly and consensually. Extraocular movements are full without signs of nystagmus or complaints of diplopia. Fundi benign with flat discs and sharp margins. Nasal passages patent. Nasal septum is in the midline. No sinus tenderness to percussion. Throat is not red. Tonsils not enlarged. Patient is edentulous with plates in place. Neck is supple. No cervical lymphadenopathy. Trachea is in the midline. Thyroid is not palpable. No arterial bruits or venous distension. Carotid upstrokes are symmetrical. Thorax is of normal configuration. Chest walls expand equally. No pain on palpation or dullness to percussion. Expiration not prolonged. No intercostal retractions. Breath sounds heard over all lung fields. Rare inspiratory crackles are heard at the bases. No expiratory wheezes noted. Precordium is noted to be quiet. PMI not displaced. Si and S2 normal. No murmurs heard. Abdomen is soft, flat and nontender. Bowel sounds normally active. No unusual pulsations. No masses or organomegaly present. No evidence of inguinal hernia. No tenderness or swelling of the thighs or calves. Varicose veins not visible. Full range of motion of all joints. Peripheral pulses are full. Sensorimotor functio normal. Cranial nerves physiologic. Deep tendon reflexes symmetrical without clonus or hyperactivity. Station and gait normal. Affect appropriate. Speech clear.

Id.

A chest X-ray is noted as abnormal with the following findings: Metallic pellets superimposed over lung fields; 8-mm calcified nodule in the left lower peripheral zone; irregular densities noted in the lower lung fields bilaterally; and parenchymal scarring with left-sided pleural thickening probably representing old chest trauma in the left upper zone. ILO Classification: s/t, 1/0. A spirogram was reported as having a 1-second forced expiratory volume (FEV1) of 2.14 liters (63% of predicted) with a 7% improvement following a bronchodilator. The lung volumes are reported as greater than normal ‘indicative of hyperinflation and air trapping”. An arterial blood gas at rest has a pH of 7.42, p02 of 72, pCO2 of 40 and an A-a gradient of 16. Following three minutes of exercise, a repeat arterial blood gas has a pH of 7.35, p02 of 71, pCO2 of 46 and an A-a gradient of 9. An electrocardiogram shows no clear-cut abnormalities. Id.

Based on his examination, Dr. Forehand concluded that the Claimant has:

> (1) Chronic bronchitis.
>
> (2) Coal workers* pneumoconiosis.

He opined:

> Based on Mr. Addison*s job description and objective tests of pulmonary function, he would be unable to return to the duties of a roof bolt operator. Mr. Addison*s pulmonary condition has left him totally and permanently disabled from meeting the physical demands of his last coal

mining job.

Id.

Evaluation

a. *Existence of Pneumoconiosis*

Pneumoconiosis is defined by the Regulations as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. The definition is not confined to 'coal workers* pneumoconiosis,* but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.
20 C.F.R. § 718.201.

This broad definition "effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines." ***Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP***, 14 B.L.R. 2-68, 2-78 (CA4 1990), 914 4th Cir. 1990), citing ***Rose v. Clinchfield Coal Co.***, 614 F.2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. ***Robinson v. Director, OWCP***, 3 B.L.R. 1-798.7 (1981); ***Tokarcik v. Consolidation Coal Co.,*** 6 B.L.R. 1-666 (1983)(chronic bronchitis secondary to coal dust exposure equivalent to CWP); ***Heavilin v. Consolidation Coal Co.***, 6 B.L.R. 1-1209 (B.R.B. 1984)(emphysema held compensable under the Act). Likewise, chronic obstructive pulmonary disease (COPD) may be encompassed within the legal definition of pneumoconiosis. ***Warth v. Southern Ohio Coal Co.***, 60 F.3d 173 (4th Cir. 1995)(COPD refers to three disease processes - chronic bronchitis, emphysema and asthma - that are all characterized by airway dysfunction).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by one of the following methods: (1) chest X-ray evidence; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by "other relevant evidence." 20 C.F.R. §§ 410.414(a)-(c).

1. *X-Ray Evidence*

20 CFR §718.202(a)(1) provides for a finding of the existence of pneumoconiosis with positive chest X-ray evidence, and that "where two or more X-rays are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiographic qualifications of the physicians interpreting such X-rays." 20 C.F.R. § 718.202(a)(1). Positive X-rays may form the basis of a finding of the existence of pneumoconiosis; however, they must be considered in light of all the relevant evidence. I am not to blindly defer to the numerical superiority of X-ray evidence, ***Adkins v. Director, OWCP***, 958 F.2d 49, 52 (4th Cir. 1992); ***Woodward v. Director, OWCP***, 991 F.2d 314 (6th Cir. 1993); ***Sahara Coal Co. v. Fitts***, 39 F.3d 781 (7th Cir. 1994); ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990), although it is within my discretion to do so. ***Edminston v. F & R Coal Co.***, 14 B.L.R. 1-65

(1990).

Box 2B(c) of the standard X-ray form indicates the quantity of opacities in the lung and therefore, the presence or absence of pneumoconiosis. The more opacities noted in the lung, the more advanced the disease; and there are four (4) categories to which a physician may choose:

> 0 = small opacities absent or less than in category 1;
> 1 = small opacities definitely present, but few in number;
> 2 = small opacities numerous, but normal lung markings still visible;
> 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured.[10]

If no categories are chosen, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis. Likewise, an X-ray which is interpreted as Category 0 (–/0, 0/0, or 0/1) demonstrates, at most, only a negligible presence of the disease and will not support a finding of pneumoconiosis under the Act or regulations. 20 C.F.R. § 410.428(c).

If the physician determines that the study is Category 1 (1/0, 1/1 or 1/2), Category 2 (2/1, 2/2 or 2/3) or Category 3 (3/2, 3/3 or 3/+), then there is a definite presence of opacities in the lung and the X-ray report may be used as evidence of pneumoconiosis. An interpretation of 1/0 is the minimum reading under the regulations which will support a finding of pneumoconiosis. A 1/0 reading indicates that the physician has determined that the X-ray is Category 1, but he/she seriously considered Category 0. As for another example, a reading of 2/2 indicates that the physician determined that the X-ray was Category 2 and Category 2 was the only other category seriously considered by the physician.

I note the divergent positions taken regarding the X-ray evidence. I do not apply significant weight to the numerosity expressed. ***Adkins v. Director, OWCP***, *supra*. However, I note that the majority of readers determined that pneumoconiosis is present on X-ray. I note that Dr. Dahhan did not read the X-ray, but relied on the reports provided.

As set forth above, Dr. Patel read the September 26, 2000 X-ray as 2, 1 (DX 13). Peter J. Barnett, M.D. found no evidence of pneumoconiosis (DX 14). Shiv Navani, M.D. read the same film as 1,0 (DX 15). Jerome Wiot, M.D. read the same X-ray as grossly under exposed and totally unacceptable (EX 2). Drs. Patel and Barnett found the quality of the film was excellent (DX 13, 14). Dr. Navani noted that the film was under exposed, but rated the quality as readable (DX 15).

Apparently, Dr. Dahhan did not have an X-ray taken when he examined the Claimant on January 23, 2001 (EX 1). On May 10, an X-ray taken at Abington Radiology Services is noted by Richard Mullins

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[10] 20 C.F.R. §§ 718.108 Chest Roentgenograms (X-rays).

III, M.D., as positive for pneumoconiosis (CX 3).

According to Dr. Forehand, the X-ray taken on July 27, 2001 is positive for pneumoconiosis and negative for the kind of evidence one sees with cigarette smoking (CX 1). Dr. De Ponte noted that the film was of excellent quality and that there was a distribution of 1,0 in all zones (CX 2). Opacities shaped q/p indicated to Dr. Deponte that there was pneumoconiosis present.

The July 27 X-ray is the most recent. Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older.[11] ***Clark v. Karst-Robbins Coal Co***., 12 B.L.R. 1-149 (1989)(en banc); ***Casella v. Kaiser Steel Corp***., 9 B.L.R. 1-131 (1986). This rule should not be mechanistically applied, however, in situations where the evidence would tend to demonstrate an "improvement" in the miner's condition. Even if the most recent X-ray evidence is positive, I am not required to accord it greater weight. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. ***McMath v. Director, OWCP***, 12 B.L.R. 1-6 (1988); ***Pruitt v. Director, OWCP***, 7 B.L.R. 1-544 (1984); ***Gleza v. Ohio Mining Co.***, 2 B.L.R. 1-436 (1979). The Board has indicated that a seven month time period between X-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. ***Tokarcik***, *supra*; ***Stanley v. Director, OWCP***, 7 B.L.R. 1-386 (1984). However, in ***Aimone v. Morrison Knudson Co.***, 8 B.L.R. 1-32 (1985), the Board held that it was proper for the administrative law judge not to apply the "later evidence" rule where eight months separated the dates of the X-ray studies. As there is a lapse of approximately nine months between the Patel X-ray and the most current X-ray, recency is a factor for consideration. I do not allot “great” weight to the fact that the July 27, 2001 X-ray is the most recent, but I attribute significant weight to it. ***Adkins v. Director, OWCP***, *supra*. That is because the finding is more consistent with the interpretations rendered by Dr. Patel and Navani, both of whom identified evidence of pneumoconiosis, than the opinion of Dr. Bennett of the the September 26, 2000 X-ray. With respect to the opinion of Dr. Wiot, with respect to the quality of that X-ray, his opinion is discounted. All of the other readers were able to read it. Dr. Navani Bennett noted that it was under exposed, but was able to read it (DX 15). If the quality of the film is not noted on the X-ray report, then it is assumed to be of acceptable quality if the study is read. ***Auxier v. Director, OWCP***, 8 B.L.R. 1- 109 (1985); ***Lambert v. Itmann Coal Co.***, 6 B.L.R. 1-256 (1983).

I note that the May 10 X-ray reading is more consistent with the reading by Dr. Patel, Navani and De

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[11] In weighing X-rays based upon the "later evidence" rule, it is the date of the study, and not the date of the interpretation, which is relevant. ***Wheatley v. Peabody Coal Co.***, 6 B.L.R. 1-1214 (1984). Generally, it is proper to accord greater weight to the most recent X-ray study of record. ***Clark***, *supra*; ***Stanford v. Director, OWCP***, 7 B.L.R. 1-541 (1984); **Tokarcik** *supra*.

Ponte although the ILO standards and findings are not provided. An X-ray interpretation need not be submitted on an official form, but may be contained in the body of a medical report. Consolidation Coal Co. v. Chubb, 741 F.2d 968 (7th Cir. 1984). I attribute significant weight to the findings in this report.

Moreover, the record reflects that Dr. Deponte is a "B" reader and board certified radiologist (CX 2, EX 2). Greater weight may be accorded the X-ray interpretation of a dually- qualified (B-reader and board-certified) physician over those physicians who are less qualified. ***Herald v. Director, OWCP***, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished); ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999) (en banc on recon.); ***Sheckler v. Clinchfield Coal Co.***, 7 B.L.R. 1-128 (1984); ***Roberts v. Bethlehem Mines Corp***., 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718). None of the other readers' qualifications were entered into the record. It is improper to accord greater weight to the interpretation of a physician whose qualifications are unknown, such as when s/he is identified only by initials. ***Stanley v. Director***, OWCP, 7 B.L.R. 1-386 (1984). The party seeking to rely on an x- ray interpretation bears the burden of establishing the qualifications of the reader. ***Rankin v. Keystone Coal Mining Co.***, 8 B.L.R. 1-54 (1985). I find that the opinion of Dr. DePonte is entitled to significant weight based on her qualifications.

b. *Autopsy or Biopsy Evidence*

20 CFR §§ 718.202(a)(2) sets forth :

> A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. A finding in an autopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis. A report of autopsy shall be accepted unless there is evidence that the report is not accurate or that the claim has been fraudulently represented.

20 CFR §§ 718.106 Autopsy; biopsy sets forth:

> (a) A report of an autopsy or biopsy submitted in connection with a claim shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure has been performed to obtain a portion of a lung, the evidence shall include a copy of the surgical note and the pathology report of the gross and microscopic examination of the surgical specimen. If an autopsy has been performed, a complete copy of the autopsy report shall be submitted to the Office.
>
> (b) No report of an autopsy or biopsy submitted in connection with a claim shall be considered unless the report complies with the requirements of this section, except that in the case of a miner who died prior to March 31, 1980, such reports shall be considered even when the reports are not in substantial compliance with the requirements of this section. Such nonconforming reports concerning miners who died prior to March 31, 1980, shall be accorded such weight and probative value as is appropriate in light of all of the evidence applicable to the individual case. (c) A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis.

[45 FR 13678, Feb. 29, 1980, as amended at 48 FR 24288, May 31, 1983]

On March 26, 2001, a bronchoscopy was performed at Johnston Memorial Hospital (CX 3). Biopsises were not performed. Therefore, the testing does not qualify as a biopsy.

c. *Presumptions*
20 CFR §§718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions in §§ 718.304, 718.305 or 718.306 are applicable. Section 718.304 provides for an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis if X-ray, autopsy, biopsy or other evidence reveals complicated pneumoconiosis. There is no evidence that presumptions apply.

d. Other Relevant Evidence
A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-rays.[12] 20 C.F.R. § 718.202(a)(4); ***Compton v. Beth Energy Mines, Inc. and Director, OWCP***, 98-B.L.A.-14 (1998).

In his reports dated September 26, 2000, Dr. Rasmussen found that the Claimant has coal workers' pneumoconiosis established by 35 years of coal mine employment and a positive X-ray (DX 10). Both Drs. Forehand and Robinette have rendered reports that opine that the Claimant has established pneumoconiosis. Dr. Dahhan takes a contrary position. Again, I do not accept that numerosity is a compelling or significant factor, but the split of opinion is noted. A review of these reports shows that they are based on objective medical evidence including blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories.

Dr. Rasmussen reviewed the evidence that was of record as of September, 2000. Dr. Dahhan rendered his opinion as of February 27, 2001, and the others rendered more recent opinions; the most recent is Dr. Forehand' s opinion dated July 1. As noted above, Dr. Dahhan had only the earlier X-ray, and did not have the May 10 and the June 27 X-ray to review. A medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. ***Gillespie v. Badger Coal Co.***, 7 B.L.R. 1- 839 (1985).

Dr. Dahhan did not have the reports from Johnston Memorial Hospital. A February 20, 2001 CT Scan

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[12] The Benefits Review Board has held that the clause in this section "notwithstanding a negative X-ray" must be read to mean "even if there is a negative X-ray." See ***Taylor v. Director, OWCP,*** 9-B.L.R. 1-22 BLA (1986). Thus, all physicians' reports must be considered, including those in which the physician's opinion is based in part upon a positive X-ray.

was performed by Casey McReynolds (CX 3). According to Dr. Robinette the CT displays a nodular pattern of interstitial disease, in the mid and upper lung zones, which is "consistent with his history of probable silicosis". Id.

20 CFR §§ 718.107, other medical evidence, sets forth:

> The results of any medically acceptable test or procedure reported by a physician not addressed in this subpart which test or procedure tends to demonstrate the presence or absence of pneumoconiosis or the sequelae of pneumoconiosis or the presence or absence of a respiratory or pulmonary impairment, may be submitted in connection with a claim and shall be given appropriate consideration.

The CT scan does not constitute an X-ray for purposes of evaluation under 20 CFR §§718.202(a). However, it can be considered in evaluating the totality of the evidence relating to pneumoconiosis. In an unpublished decision in ***Keene v. G&A Coal Co.***, BRB No. 96-1689 BLA-A (Sept. 27, 1996), the Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. § 718.304. It held that the ALJ properly found that a chest X-ray, in conjunction with CT scan findings, was sufficient to find complicated pneumoconiosis. Moreover, with respect to Dr. Dahhan's opinions, although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, i.e., X-ray, blood gas, and ventilatory studies. ***Minnich v. Pagnotti Enterprises, Inc***., 9 B.L.R. 1-89, 1-90 n. 1 (1986); ***Wetzel v. Director, OWCP***, 8 B.L.R. 1-139 (1985).

I also accept that Dr. Dahhan gave excessive credit to the opinion rendered by Dr. Wiot that the X-ray taken September 26, 2000 was not readable. A review of his report shows that it is bottomed on a false assumption regarding the X-ray evidence in both quantity and quality. For that reason, alone I attribute less weight to his opinion. See ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999). This is compounded by the fact that he did not have access to the CT scan and the bronchoscopy report, as well as the latest reports from Dr. Robinette, the treating physician. Greater weight may be accorded that opinion which is supported by more extensive documentation over the opinion which is supported by limited medical data. ***Sabett v. Director, OWCP***, 7 B.L.R. 1-229 (1984). An opinion may be given less weight where the physician did not have a complete picture of the miner's condition. ***Stark v. Director, OWCP,*** 9 B.L.R. 1-36 (1986).

Also, I note that Dr. Dahhan's qualifications are not of record. Dr. Robinette is a board certified chest physician (CX 3). With the exception of Dr. Michos, the other examining physicians' qualifications are not of record. Therefore I accept that Dr.Robinette is better qualified to render the opinion than Dr. Dahhan. Moreover, Dr. Robinette is a treating physician. The length of time in which the physician has treated the miner is relevant to the weight given the physician's opinion. ***Revnack v. Director, OWCP***, 7 B.L.R. 1-771 (1985). The record shows that Dr. Robinette examined, operated upon and treated the Claimant from February, 2001 to the present. Therefore I accept that Dr.Robinette's opinion is entitled to greater weight than that of Dr. Dahhan.

I also accept that both Dr. Forehand and Dr. Robinette rendered well documented and reasoned opinions with respect to the existence of pneumoconiosis. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction Co.***, 8 B.L.R. 1-65 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127 (1984). Indeed, a treating physician's opinion based only upon a positive X-ray interpretation and claimant's symptomatology was deemed sufficiently documented. ***Adamson v. Director, OWCP***, 7 B.L.R. 1-229 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. Fields, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989)(en banc).

I also noted previously that the record reflects that Dr. Deponte is a "B" reader and board certified radiologist (CX 2, EX 2). I therefore attribute substantial weight to he diagnosis of pneumoconiosis on that basis. I also note that Dr. Robinette's opinion is substantiated by that of Dr. Forehand and by the X-ray taken on June 27 and read by Dr. De Ponte. According to Dr. Forehand, that X-ray is positive for pneumoconiosis and negative for the kind of evidence one sees with cigarette smoking (CX 1). Dr. De Ponte noted that the film was of excellent quality and that there was a distribution of 1,0 in all zones (CX 2). Opacities shaped q/p indicated to Dr. Deponte that there was pneumoconiosis present. I have also noted that the July 27 X-ray is the most recent. Therefore, I credit that opinion regarding the existence of pneumoconiosis rendered by Dr. Forehand (and De Ponte).

I have also previously noted that the May 10 X-ray reading is more consistent with the reading by Dr. Patel, Navani and De Ponte, and that I attribute significant weight to the findings in that report.

Therefore, based on a review of all of the evidence of record, I find that the Claimant has established that he has pneumoconiosis under 20 CFR §§718.202(a) (1) and (4). I find that each section applies independently and in the alternative. Not only does the preponderance of the evidence reflect that pneumoconiosis is established on X-ray, the Claimant has provided physician reports, exercising sound medical judgment, that show that the miner suffers or suffered from pneumoconiosis as defined in §718.201. The opinions are based on objective medical evidence from physical examinations, and medical and work histories, as well as appropriate testing.

Etiology of Pneumoconiosis

In order to find a Claimant eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. 20 C.F.R. § 718.203(a). Where a

miner is credited with ten (10) or more years of coal mine employment and is suffering from pneumoconiosis, it will be presumed, in the absence of contrary evidence to the contrary, that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten (10) years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the parties have stipulated that the Claimant had twenty (20) years of coal mine employment, he receives the presumption that his pneumoconiosis arose out of coal mine employment. And since the record does not contain contrary evidence that shows the Claimant's pneumoconiosis arose out of alternative causes, I find that Claimant's pneumoconiosis arose from his coal mine employment.

Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(1). Section 718.204(b)(2) provides the following methods for establishing total disability: (1) qualifying pulmonary functions tests; (2) qualifying arterial blood gas studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions; and (5) lay testimony.[13] Additionally, pneumoconiosis must be a "contributing cause" to the miner's total disability. Hobbs v. Clinchfield Coal Co., 917 F.2d 790, 792 (4th Cir. 1990). Therefore, a claimant must first establish that he is totally disabled and second, that his pneumoconiosis is a contributing cause to his disability.

1. *Total Disability*

a. *Pulmonary Function Tests*

As previously stated, total disability may be established with qualifying pulmonary function studies. The quality standards for pulmonary function tests are located at 20 C.F.R. § 718.103 and require that each study be accompanied by three (3) tracings, ***Estes v. Director, OWCP***, 7 B.L.R. 1-414 (1984), and that the reported FEV1 amd FVC or MVV values constitute the best efforts of three trials. Furthermore, I may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. ***Houchin v. Old Ben Coal Co.***, 6 B.L.R. 1-1141 (1984); Runco v. Director, OWCP, 6 B.L.R. 1-945 (1984). To be qualifying under the regulations, the FEV1 and either the MVV or FVC values must be equal to or less than those values listed at Appendix B for a miner of similar age, gender and height.[14]

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[13] The Board has held that a judge cannot rely solely upon lay evidence to find total disability in a living miner's claim. ***Tedesco v. Director, OWCP,*** 18 B.L.R. 1-103 (1994).

[14] Based upon the record, the Claimant's height is 68.75 inches (average between the three reported heights).

Exhibit	***Date***	***Physician***	***FEV1***	***FVC***	***MVV***
DX 10	9/11/00	Rasmussen	2.07	4.07	61
CX 3	2/20-26/01	Robinette	1.86	3.17	
EX 1	2/23/01	Dahhan	2.12	3.43	76
CX 1	6/27/01	Forehand	2.14	3.84	64

At age 52/53, none of the tests qualify under Table B of the Regulations. 20 C.F.R. § 718, App. B, although the testing is positive. Therefore, Claimant cannot establish total disability via his pulmonary function tests.

b. *Blood Gas Studies*

Section 718.204(b)(2)(ii) provides that a claimant may prove total disability through evidence of qualifying blood gas studies. Moreover, Claimant's arterial blood gas levels must correspond to the values in Appendix C. 20 C.F.R. § 718.204(b)(2). According to Appendix C, for tests conducted at sites up to 2,999 feet above sea level, the sum of Claimant's PCO2 and PO2 levels must be equal to or less than 100 mm Hg. Although Dr. Rasmussen noted hypoxia and significant gas exchange problems, none of the arterial blood gas studies presented are qualifying.

The Claimant has failed to carry his burden of establishing total disability pursuant to blood gas study evidence.

c. *Evidence of Cor Pulmonale*

Under 20 CFR §§718.204(b)(2)(iii), total disability may be proven through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

d. *Physician Opinion Evidence*

Lastly, the regulations provide that a claimant may prove total disability where a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(iv). The Claimant must first compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. ***Schetroma v. Director, OWCP***, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a prima facie finding for total disability is made, thereby shifting the burden to the party opposing entitlement to prove that the claimant is able to perform gainful and comparable and gainful work, as defined pursuant to 20 C.F.R. § 718.204(b)(2). ***Taylor v. Evans and Grambrel Co.***, 12 B.L.R. 1-

83, 1-87 (1988).

The Claimant testified that he was a roof bolter (Tr., 9). According to the ***Dictionary of Occupational Titles*** ("***DOT***")- Fourth Edition, Revised (United States Department of Labor, 1991), the exertional requirement for the job is "medium". This is defined as:

> Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.[15]

The job duties consist of the following:

> Operates self-propelled machine to install roof-support bolts in underground mine: Positions safety jack to support roof until bolts can be installed. Drives machine into position, inserts bit in drill chuck, and starts drill. Moves lever to advance bit into roof at specified distance from rib or adjacent bolt. Removes bit from chuck and replaces with bolt. Starts hydraulic action which forces bolt into hole. Starts rotation of chuck to turn bolt and open expansion head to exert pressure upon rock formation. Tests bolt for specified tension, using torque wrench. May install truss bolts traversing entire ceiling span and tighten ends of anchored truss bolts, using turnbuckle.

DOT Number 930.683-026, Roof Bolter (mine & quarry); alternate titles: bolting-machine operator; raise driller.

According to Dr. Forehand, Mr. Addison does not have the ventilatory capacity to return to his prior job as a roof bolter. (EX 1). Dr. Forehand is board certified in pediatrics and in allergy and immunology (Id.). Dr. Forehand notes that the Claimant has lost 37% of his ventilatory capacity. He notes that as a roof bolter, the Claimant was exposed to the "highest levels of silica (the most toxic contaminent of coal dust)). He cited to the June , 1992 ***Department of Labor Report of the Coal Mine Task Force*** and to a learned journal article.[16] In ***Church v. Eastern Assoc. Coal Corp***., 20 B.L.R. 1-8 (1996), the Board held that it was proper to accord greater weight to a medical report "on the grounds that the doctor specifically identified the studies upon which he relied and the conclusion he reached was consistent with the underlying objective evidence of record." Moreover, the administrative law judge correctly assigned greater weight to a treating physician's opinion whose diagnosis was based upon "extensive medical information gathered over a period of many years."

Dr. Dahhan noted abnormal pulmonary function studies. He opined that the Claimant has total respiratory disability. However, he considers that this is not a result of pneumoconiosis as there is a significant response to bronchodilation, and "normal diffusion studies". Dr. Dahhan concedes that the

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[15] ***DOT***, Appendix A.

[16] Rainey LC, P Bolsaitis, B Dirsa, lB Vander Sande. Characterization by scanning transmission electron microscopy of silica particles from alveolar macrophages of coal miners. ***Environ Health Perspect*** 102:862, 1994.

Claimant can not return to his former work due to obstructive airway disease. However he opines this is due to tobacco smoking, which caused the obstructive abnormality (EX 1). He also remarks that the reversibility infers that the obstructive disease in not pneumoconiosis.

I have already discussed that I discounted Dr. Dahhan's opinion regarding the existence of pneumoconiosis. I noted the fact that his report fails to consider the bronchoscopy report and the CT scan. I also noted that Dr. Forehand's examination of Mr. Addison was more recent. I also noted that Given that Dr. Dahhan did not have all of the relevant evidence before him when he rendered report, and given that he failed to take an X-ray, relying on the extant record, recency is relevant. Dr. Dahhan's qualifications are not of record, and therefore other physicians are better qualified than he to render an opinion as to the existence of pneumoconiosis. I also accept that Dr. Dahhan gave excessive credit to the opinion rendered by Dr. Wiot that the X-ray taken September 26, 2000 was not readable. A review of his report shows that his logic is bottomed on a false assumption regarding the X-ray evidence in both quantity and quality.

I also note that the reports and findings of Dr. Rasmussen and Dr. Robinette substantiate the opinion rendered by Dr. Forehand. Dr. Rasmussen found that ventilatory function studies revealed a moderate, slightly reversible obstructive insufficiency. Maximum breathing capacity was markedly reduced; however, it was less than the calculated values of 83 and 91 L/min. respectively. Minimal resting hypoxia is also noted. Although Dr. Dahhan noted the smoking history, Dr. Rasmussen performed a single breath carbon monoxide diffusing capacity, which was reported as "normal". This is the test administered to identify smoking . This is consistent with Dr. Forehands observation about the X-ray and the CSX testing he administered and a basis to rule out tobacco usage. Dr. Robinette performed the bronchoscopy and the CT scan and May 10 X-ray were performed on his watch. In his last reports he notes "probable" coal workers' pneumoconiosis and silicosis (CX 3).

Dr. Forehand relied in part, on the X-ray taken June 27, 2001, and a review of a more complete and later examination, and I accept that his report is more thorough and his opinion is more rational than that of Dr. Dahhan. Fields, supra. For example, Dr. Dahhan does not fully explain why bronchodilation would exclude, preclude or rule out a diagnosis of coal workers' pneumoconiosis. He does not relate his opinion regarding the effects of the Claimant's smoking to the findings of record. And more importantly, the opinion is based the opinion of Dr. Wiot that has been discredited and on numerous findings that were not part of the record when Dr. Dahhan rendered his opinion. I also accept that Dr. Forehand is better qualified to render an opinion as to total disability, as Dr. Dahhan's qualifications are not of record and Dr. Forehand is board certified in a related field. Therefore for the forgoing reasons, I discount Dr. Dahhan's opinion as to total disability.

I accept that the Claimant's work as a roof bolter required him to lift to fifty pounds occasionally and carry objects weighing to 20 pounds regularly. I accept the Claimant's pneumoconiosis precludes performance of the exertional requirements of this work. I also accept that the work involved working in coal dust and that from an environmental standpoint, the Claimant's pneumoconiosis does not permit

a return to this work.

2. *Causation*

Although the weight of the evidence sufficiently demonstrates that Claimant is totally disabled, he must still establish by a preponderance of the evidence that his disability is caused by his coal workers' pneumoconiosis. That is, the claimant must prove that his pneumoconiosis is a "substantially contributing cause" to his totally respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c)(1); ***Milburn Colliery Co. v. Hicks***, 138 F.3d 524, 529 (4th Cir. 1998). To be a contributing cause, the claimant's coal mining must be a necessary condition of his disability. If the claimant would have been disabled to the same extent and by the same time in his life if he had never been a miner, then claimant has failed to meet his burden. On the other hand, if his mining has contributed to his disability, then the burden is met. ***Robinson v. Pickands Mather & Co.***, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990).

Again, according to Dr. Forehand, the Claimant's total disability is a result of pneumoconiosis (CX 1). Dr. Dahhan accepts that the Claimant is totally disabled, but solely as the result of smoking (EX 1). I also note that Dr. Forehand performed a battery of tests that include the diffusing capacity, etc. which belie Dr. Dahhan's conclusions regarding the genesis of his total respiratory disability. Also, according to Dr. Forehand, the X-ray taken on July 27, 2001 is negative for the kind of fibrosis consistent with cigarette smoking (CX 1). Moreover, according to Dr. Forehand, the CXR test, displays no evidence of emphysema usually associated with cigarette smoking (Id.). I find that this is persuasive.

Moreover, as to any inference that the total respiratory disability is not as a result of pneumoconiosis, because of "reversibility", this argument harkens to a time when there was a dispute whether pneumoconiosis can be an obstructive disorder. The Board has held that an obstructive impairment, without a restrictive component, may be considered regulatory pneumoconiosis. ***Heavilin v. Consolidation Coal Co.***, *supra*. "Pneumoconiosis" is a legal term defined by the Act and the judge "must bear in mind when considering medical evidence that physicians generally use 'pneumoconiosis' as a medical term that comprises merely a small subset of the afflictions compensable under the Act." Thus, an administrative law judge should review evidence in light of the much broader legal definition. ***Barber v. Director, OWCP***, 43 F.3d 899 (4th Cir. 1995). In ***Richardson v. Director, OWCP***, 94 F.3d 164 (4th Cir. 1996), the court reiterated that "[c]linical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act" and that "COPD[17], if it arises out of coal mine employment, clearly is encompassed within the legal definition of pneumoconiosis, even though it is a disease apart from clinical pneumoconiosis." [18]

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[17] Chronic obstructive pulmonary disease.

[18] The Fourth Circuit held, in ***Warth v. Southern Ohio Coal Co.***, *supra*, that chronic obstructive lung disease is encompassed in the legal definition of pneumoconiosis. Thus, the assumption by a physician that pneumoconiosis causes a restrictive impairment, rather than an obstructive

I note that if Dr. Dahhan relied on the false premise that pneumoconiosis can not be an obstructive disease, his opinion remains that the Claimant is "totally disabled". I find that total disability stems albeit from another source – pneumoconiosis. For all of the above reasons, I credit the opinion of Dr. Forehand and discount the opinion of Dr.Dahhan.

Therefore, based a review of the entire record, I accept that the Claimant is totally disabled as a result of pneumoconiosis. 20 CFR §§718.204.

ORDER

IT IS ORDERED that the claim for benefits filed by Bobby Wayne Addison is granted. The Employer, Shady Lane Coal Co. shall:

1. Pay to the Claimant, all benefits to which he is entitled, including augmented benefits to his dependent wife, Sherri Addison, under the Black Lung Benefits Act, commencing as of June 1, 2000, the month in which the Miner became entitled (33 U.S.C. §§ 906(a));
2. Pay to the Secretary of Labor reimbursement for any payment the Secretary has made to Bobby Wayne Addison under the Act, and to deduct such amounts, as appropriate, from the amount the Employer is ordered to pay under paragraph 1 above;
3. Pay to the Secretary of Labor interest as provided by law under Section 6621 of the Internal Revenue Code of 1954. Interest is to accrue thirty (30) days from the date of the initial determination of entitlement to benefits. 20 C.F.R. §§ 725.608.
4. Claimant's attorney is granted thirty (30) days to submit an application for fees conforming to the requirements of 20 C.F.R. §§ 725.365 and §§ 725.366.

SO ORDERED.

A
Daniel F. Solomon
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.

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impairment, is erroneous and undermines his conclusions. But see ***Stiltner v. Island Creek Coal Co,*** 86 F.3d 337 (4th Cir. 1996)(a physician's opinion should not be discredited merely because he states that coal dust exposure would "likely" cause a restrictive, as opposed to obstructive, impairment).